APPENDICES

PRIMARY, SECONDARY, AND TERTIARY PREVENTION DEFINITIONS*

Approaches to prevention are often classified as primary, secondary, or tertiary efforts, depending on where in the natural history of disease they are directed. This classification provides a useful framework for summarizing various types of prevention activities.

PRIMARY PREVENTION

Primary prevention activities are directed at well persons during the period of susceptibility and are intended to prevent the initial development of the pathologic process. Smoking cessation programs are an example of a primary prevention approach to both lung cancer and cardiovascular disease. Programs designed to reduce risk factors for chronic disease by health education efforts that alter personal health behaviors such as smoking, diet, exercise, and others are examples of primary prevention programs.

SECONDARY PREVENTION

Secondary prevention activities involve early detection and treatment of persons with asymptomatic disease: Papanicolaou cytology screening programs for cervical cancer and mammography screening for breast cancer are examples of secondary prevention approaches.

TERTIARY PREVENTION

Tertiary prevention efforts are directed at arresting the progression of disease in persons with established illness. Diabetes control programs, designed to prevent the development of complications such as retinopathy and the need for limb amputations, are examples of tertiary programs. Cost effective tertiary interventions have the potential to reduce substantially the burden of disability and death in those already afflicted with chronic disease as well as in the increasing number of such persons anticipated in the aging American population.

*Definitions adapted from: The Prevention and Control of Chronic Disease: Reducing Unnecessary Deaths and Disability - A Conference Report, Mason, Koplan, Layde, Public Health Reports, January-February, 1987.

S A M P L E

Scope of Work Contractor's Name

Goal I: Outreach and Health Education

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
1. OUTREACH: Target areas and communities where older adults, aged 55 and above, lack access to, or are not using available preventive services. ***(REQUIRED OBJECTIVE)***	1.1 Coordinator will establish a minimum of 14 PHCA clinic sites where need for PHCA services has been identified. (1) See "Mayo County Clinic Site List" for proposed sites and targeted population. (2) PHNs will post PHCA signs/posters in strategic locations at each clinic site during clinic operation. (3) PHNs will, when feasible, schedule "ask the nurse" time during regularly scheduled clinic hours for unscheduled seniors who may have specific questions or needs.	11/1/04 through 06/30/06	1.1 Annual report lists: (1) Number of new clinic sites (2) Number of clinic sites discontinued (3) Total number of clinic sites used
	1.2 Volunteers and outreach workers in the PHCA program will distribute flyers and posters in key areas where seniors gather or use services: (1) Key areas may include (but are not limited to) senior centers, park and recreation centers, grocery stores, pharmacies, clinics serving seniors, transit stops, malls, churches, food markets, beauty parlors/barber shops, mobile home parks. (2) Coordinator will explore the opportunity and feasibility of including PHCA flyers with local utility bills or bank statements mailed in targeted areas. (3) PHCA staff attending the Mayo County Senior Network meeting will provide members with print materials for distribution to seniors and seniors service programs.		1.2 Annual report provides information about effectiveness of outreach activities.
	1.3 PHCA staff, volunteers or outreach workers will contact at least 4 radio and/or television stations: (1) Identify and schedule opportunities to use public access time or "community bulletin boards" to promote PHCA and prevention services. (2) Offer PHCA program staff for live or taped interviews.		1.3 Number of radio and/or television stations used to promote PHCA is listed in annual report. Key interviews of program staff and successful ads are described.

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Scope of Work Contractor's Name

Goal I: Outreach and Health Education

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
	1.4 Community Outreach Worker will contact at least 2 local newspapers that reach seniors to include announcements of PHCA services and clinic locations and contact numbers.	11/1/04 through 06/30/06	1.4 Number of local newspapers used to promote/advertise PHCA is listed in annual report. Effective ads and/or copies of articles are included as attachments to annual report.
	1.5 All new CHA clients will be asked where they heard about PHCA and what convinced them to appoint. Results will be tallied quarterly.		1.5 Quarterly tallies are compiled and reported in annual report to describe most effective outreach activities used to recruit new clients.
	1.6 At-risk seniors who have previously received a CHA in past year will be contacted and invited to schedule a CHA..		
2. NETWORKING: To participate in local coordinating networks to promote the delivery of preventive health services for older adults. ***(REQUIRED OBJECTIVE)***	2.1 Meetings of the PHCA Advisory Board, consisting of representatives of senior health and service providers in the community, including a representative from Area I Agency on Aging, will be held on a quarterly basis		2.1 "Community Meetings" report listing networks participated in is submitted with annual report.
	2.2 A representative of the PHCA program will participate in meetings of the California Osteoporosis Prevention and Education (COPE) Program. Meetings will be held on a monthly basis.		2.2 "Community Meetings" report listing networks participated in is submitted with annual report.
	2.3 A representative of the PHCA program will serve as a participant of the Latino Providers' Network. Meetings will be held on a monthly basis.		2.3 "Community Meetings" report listing networks participated in is submitted with annual report.
	2.4 The Mayo County District PHN working with the PHCA Program will attend monthly meetings of the Mayo Senior Services Commission of the Area Agency on Aging.		2.4 "Community Meetings" report listing networks participated in is submitted with annual report.
3. HEALTH FAIRS: PHCA will attend and/or assist in coordinating health and information fairs to promote PHCA services and provide focused	3.1 PHCA staff will attend and/or assist in coordinating at least 2 health and information fairs in local targeted communities to promote PHCA services and/or provide focused screens and/or health information to targeted seniors:		3.1 PHCA''s role for each health fair, event themes, activities and attendance, is described in annual report. Number of clients receiving health information or screens is reported on "Total Population Worksheet" and included in annual report.
	(1) Specific PHCA activities will be developed with event planners.		

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Scope of Work Contractor's Name

Goal I: Outreach and Health Education

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
health assessments and/or health information to targeted seniors.	(2) PHCA will present at least 2 health promotion activities. (3) PHCA will participate in promotion and outreach activities for health fair. (4) PHCA will identify, for health fair planning council, resources available within local county and health service agency, and promote fair within the agency.	11/1/04 through 06/30/06	
4. SCREENING CLINICS: PHCA will conduct special screening clinics as a means of early disease detection for groups considered "high-risk" for such conditions.	4.1 Coordinator, in consultation with local public health staff, will identify target communities, recruit local collaborating health providers and community organizations (if applicable), and develop plans that include: (1) Selection of sites and screening services to be provided (2) PHCA and community providers who will staff clinics (3) Outreach and promotion of clinics in target areas (4) Referral and follow-up procedures for abnormal screening results, including identification of medical care providers who will accept referrals for seniors without insurance (5) Health promotion activities, e.g., handouts, nutrition counseling, physical activity promotion, to be provided concurrent with clinic (6) Method for reporting and evaluating results of the screening clinics among collaborating partners		4.1 Screening clinic activities are reported in annual report. Collaborating partners are identified. Total number of seniors screened, number of abnormal results detected, number of referrals made, and number of referrals followed up, are reported in annual report. Unique clients are tallied annually on the "Total Population Served" Worksheet.
	4.2 Seniors at risk, based on screening results, will be recruited for PHCA clinics. Coordinator will schedule special pilot clinic sites in easily accessible areas if current PHCA clinic sites are not accessible to senior in these communities.		4.2 Number of at-risk seniors appointing to CHA clinics for further PHCA services is reported.
5. GROUP HEALTH EDUCATION: (Continued on next page)	5.1 A minimum of 16 group health education presentations will be made at 4 community sites.		5.1 Description of PHCA collaboration and planning Health Education presentations; number of presentations made, description

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Scope of Work Contractor's Name

Goal I: Outreach and Health Education

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
Develop and deliver community health education presentations targeting the needs and risk-factors of local seniors.	(1) Sites will be selected based on current or previous access by older adults to this information and data from PHCA assessments indicating a lack of knowledge about risks and preventive screening needs. 5.2 (List all agencies to be contacted in assisting in planning or conducting the presentations, identifying presenters, and obtaining relevant audio-visual and printed materials). (1) Instructors will include PHCA staff and knowledgeable community health providers. (2) PHCA will provide overall planning and coordination of these presentations. (3) Outreach materials about PHCA and collaborating organizations will be available at each presentation	11/1/04 through 06/30/06 ↓	of topics, sites used, and number of seniors attending is reported annually. Number of participants is tallied and listed on "Total Population Served" worksheet that is included with annual report.
6. HEALTH RISK REDUCTION ACTIVITIES: Develop a 2-year cardiovascular(CVD) risk reduction program for women aged 55 and older to (1) raise awareness of women's risk for CVD, and (2) develop multiple activities to address these risks. <u>Year #1</u>: Develop a partnership, an action plan, and	6.1 <u>Year One of Two-Year Objective</u> Convene a partnership of interested parties with knowledge and expertise in CVD, who are willing to commit time and resources to implementing planned activities in local communities. (1) PHCA will contact Cardiovascular Outreach, Resources and Epidemiology Program (CORE) at DHS to obtain local CVD data and assistance in partnership development. (2) Partnership will do the following: Develop goals, activities, and an action plan to implement selected activities. (a) Identify and obtain a commitment from all resources that will be needed to implement plan. (b) Develop criteria for evaluating all project activities. (c) Identify data collection needs to evaluate outcome of all activities and to base future planning. (d) Implement year one of risk reduction plan.		6.1 Annual report lists partnership membership, summary of year-one risk reduction plan, partnership meetings held, resources committed to implement activities, and year-one activities completed as planned or modified.

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Scope of Work Contractor's Name

Goal I: Outreach and Health Education

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
committed resources. Select 2 sites to pilot risk reduction activities. <u>Year #2</u>: Expand sites and geographic areas for selected activities. Invite new community providers and interested parties from these areas to participate in the partnership.	6.2 Develop an outreach plan to raise awareness of CVD risk in women age 55 and older. (1) Partnership will develop and secure appropriate CVD risk awareness education materials that are appropriate to targeted groups. (2) Plan will include outreach to women and providers, and may include (but will not be limited to): (a) Use of print and broadcast media with response system for additional information (b) Public presentations at sites accessible to older women (c) Meeting with medical professionals and provider groups (d) Dissemination of information to churches, civic and professional organizations, and other groups that include older women in their membership (3) Outcome of activity may be measured by response of each targeted group, by requests for additional information, attendance at group presentations, and target surveys to a selection of responders. 6.3 Select two communities with identified high-risk population to pilot CVD risk reduction activities. Risk factors will include nutrition/weight management, physical activity, stress reduction, and smoking cessation. Medical management of women with CVD will be included when health care providers are targeted. (1) Implementation activities may include (but are not limited to): (a) Community health education through media. (b) CVD health fairs or other community events in sites accessible to women. (c) Distribution of printed and video materials on CVD risk reduction. (d) Incorporation of counseling and/or use of educational materials by medical care providers with women identified at high risk or those with diagnosed CVD. (e) Appointment to a PHCA clinic for assessment services.	11/1/04 through 06/30/06 ↓	6.2 Annual report summarizes all outreach activities including presentations made, partnership or community members making presentations, and responses by targeted groups to these outreach activities. 6.3 Implementation of all activities is described in annual report, including results of all data collected in year one.

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Goal I: Outreach and Health Education

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
	(2) Partnership will develop and implement plan for data collection to evaluate the outcome of all activities in selected communities: (a) A survey will be given to willing participants who receive one-to-one services for determination of current risk factors and willingness to change. This group will be re-surveyed in year two of this project to determine if changes occurred in areas such as smoking cessation/reduction, weight management, increased physical activity, improved nutrition. (b) Willing medical providers will be surveyed to determine their use of focused counseling and educational materials about CVD risk reduction for women in their practice, and their desire to have access to additional educational materials ongoing. (3) Partnership risk-reduction action plan will be implemented in two selected communities. (a) Activities will be monitored for additional resource needs. (b) Outcomes may include (but are not limited to) number of women served through these activities, results of the initial survey, and response of participating medical providers. 6.4 Partnership will evaluate results and effectiveness of implementation of action plan. Evaluation may include: (1) Interest and commitment of partnership members, and ability of group to develop committed resources for planned activities; (2) The extent to which original action plan could be implemented or needed to be modified during year; (3) The response to outreach and awareness in bringing women into planned risk reduction activities in targeted communities; (4) The partnership's plan to expand and modify these activities in year two.	11/1/04 through 06/30/06 ↓	6.4 Annual report includes description of evaluation process, results, barriers to implementation of activities as planned, modifications made, and summary of activities to be continued and/or started in year two.

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Scope of Work Contractor's Name

Goal I: Outreach and Health Education

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
7. HEALTH CARE MAINTENANCE: Health Care Maintenance (HCM) will be provided to CHA clients Presenting with complex health issues or new conditions requiring self-care knowledge.	7.1 A minimum of 10% of CHA clients will receive health care maintenance services annually. Clients to be targeted for HCM services will be those who present with multiple and/or complex health status, or medical conditions requiring self-care knowledge. Based on mutual consent with client and PHN, HCM visits will be scheduled to reach targeted health goals (1) A plan outlining goal(s) of HCM sessions will be listed in client's chart and discussed in order to gain mutual agreement between client and PHN. (2) Action steps to reach goals will be defined at each HCM session. (3) Helpful information, resources and referrals to other services will be provided at HCM visits. (4) Outcomes monitored by regular follow-up during HCM visits or non-CHA contacts. (5) HCM will be discontinued based on evaluation that goals have been reached, action steps have been completed, or client wishes to discontinue HCM.	11/1/04 through 06/30/06 ↓	7.1 Annual report includes number of clients served with HCM service and description of any key success stories (e.g. improved health status due to HCM education, identification and development of key community resources in reaching HCM goals for a particular client).

Scope of Work Contractors Name

Goal II: Health Assessments and Data Collection

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
1. Provide _____ *(range starts with minimum number required)* Comprehensive Health Assessments (CHAs) consistent with the required "CHA Standards of Care."	1.1 Maintain a minimum of _____ assessment sites in outreach settings where CHAs are provided. (1) A current list of assessment sites will be maintained and made available upon request.	11/1/04 through 06/30/06	In Annual Reports: 1.1 An individual health record is maintained for each client. The record includes: health history, nutrition assessment, data forms, and the client health plan. DHS 8034 (Encounter Form) completed for each client encounter on PHCA time where a professional service was provided. ***Compliance:*** **Completed** **Yes** ☐ **No** ☐ **Number of CHAs completed_____**
	1.2 Protocols applicable to contractor's clinical assessment practices shall be developed before assessment services are begun. Protocols will be available to all PHCA staff. (1) Protocols will be reviewed periodically (at least annually) and revised to include changes needed to accurately guide clinic assessment performance.		1.2 Protocols available for State review on request. *Copy of Protocols index and form depicting most recent annual review and sign-off by local health officer, nursing supervisor, PHCA Coordinator, provided in* **Appendix #_____**
2. Provide each client counseling and instruction based on the client's health history, diet and the results of the client assessment.	2.1 Provide counseling/instruction to each CHA client based on health risks identified through the assessment and the client-selected activities identified on the client health plan.		2.1 Counseling interventions greater than 10 minutes in duration are coded on the Encounter Form (DHS 8034). ***Compliance:*** **Completed** **Yes** ☐ **No** ☐
3. After each CHA in collaboration with the client, PHN will develop a written plan for the client's priorities and activities for achieving optimum health and function.	3.1 PHN will review results of the CHA with the client and will record PHN-identified health risks on the client's health plan: (1) PHN will identify the physical, mental, social, functional, and economic problems; health behavior risk factors, preventive health screening needed, and symptoms or medical problems needed evaluation by a health care practitioner. (2) PHN will reinforce current good health practices and		3.1 A copy of the client's health plan reflects the health risks identified by the PHN. ***Compliance:*** **Completed** **Yes** ☐ **No** ☐

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Goal II: Health Assessments and Data Collection

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
	assist the client in setting priorities, locating community services, and choosing activities to maintain or improve their health status. 3.2 PHN will assist the client to develop a health plan; this plan will include: (1) Specific goals and activities the client agrees to address (2) Method by which the client will achieve each health plan goal, or complete a specific activity (including the resources available) (3) Time frame to start and/or complete or continue each health plan goal or activity (4) Date and purpose of the next clinic contact or visit. 3.3 PHN and the client will decide if additional PHCA services will be provided beyond the CHA. This decision shall be based on the specific risk factors identified during the CHA and client's willingness to address these issues with the assistance of the PHN. (1) Client agrees to participate in additional PHCA activities, these activities are included in the client's health plan. 3.4 A copy of the health plan will be given to client after each CHA. (1) Plan will be updated during the year as appropriate. (2) Plan will be reviewed with the client at the next CHA to determine the status or completion of all chosen activities.	11/1/04 through 06/30/06	3.4 A completed copy of the client health plan is filed in the client's health record. ***Compliance:*** **Completed** **Yes** ☐ **No** ☐
4. Assist clients to identify and use appropriate health (Continued on next page)	4.1 Clients shall be referred to other health and social resources based on the results of the CHA and the client health plan.		4.1 Referrals are documented on DHS 8034 Encounter Form. ***Compliance:*** **Completed** **Yes** ☐ **No** ☐

Scope of Work Contractors Name

Goal II: Health Assessments and Data Collection

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
resources that address their individual health needs.		11/1/04 through 06/30/06	*A brief narrative of notable referrals made during this reporting period included in* ***Appendix #_____***
	4.2 Referral guidelines for asymptomatic clients, for periodic preventive services not provided by the contractor, will be available to PHCA staff.		4.2 Preventive referral guidelines areavailable for State review upon request. *(See Protocol index)*
	4.3 All clients with a potential medical problem identified during the CHA will be referred to a medical care practitioner (or dentist) for further evaluation. Clients reporting current situations involving elder abuse or domestic violence shall receive appropriate referrals for help; mandatory reports will be made according to protocol (to either the local Adult Protective Services agency or the local police).		4.3 Referral Follow-up Form (DHS 8448) used for documentation of the outcomes for medical referrals. A copy is placed in client's health record. ***Compliance:*** **Completed Yes ☐ No ☐**
	(1) Outcome of at least 75% of these referrals shall be documented within three months of the referral date.		**_____% referrals documented within 3 months of referral date.**
5. Required data will be collected with each client encounter and submitted in a timely manner according to deadlines listed on the PHCA Data Timeline schedule.	5.1 All PHNs and PHCA staff with data collection and coding responsibilities will develop proficiency in data collection.		5.1 Data Manual instructions are followed in completing data forms. ***Compliance:*** **Completed Yes ☐ No ☐**
	(1) PHCA staff will attend required trainings on data collection and management; new staff will receive instruction on data collection coding at the local level.		
	(2) PHCA data manual will be available for use by all staff with data collection responsibilities.		
	(3) Program coordinators will contact the State Office with data coding questions that are not covered by manual instructions.		
	5.2 Required data forms will be accurately coded and reviewed for errors and omissions.		5.2 Data forms are accepted by the data system as submitted or corrected; contractor's error rate does not exceed 35% for CHA, Non-CHA and Referral forms submitted.
	(1) Forms with data errors will be returned to the contractor, corrected promptly and resubmitted.		**_____ % of errors on CHA forms (see table 1-8)**

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Goal II: Health Assessments and Data Collection

Major Objectives	Major Functions, Tasks, Activities	Time Line	Performance Measure and/or Deliverables
	5.3 Data forms will be submitted accurately, and in a timely manner that meets performance standards set by the State Office. (See PHCA Data Timeline for due dates).	11/1/04 through 06/30/06	5.3 Pattern of data forms submission, as determined from Shipment Logs, demonstrate regular and timely forms submission. ***Compliance:*** **Completed** **Yes ☐ No ☐**
6. PHCA coordinators and program managers will use data tables to verify contract Scope of Work compliance, monitor delivery of services, and track the health status and demographic information about the older adults who receive CHA services.	6.1 Local data may be used to: (1) Monitor outreach activities to verify that the intended target population is served. (2) Identify the frequency of common health problems which future Scope of Work activities may address.		6.1 Required program reports utilize local data to support compliance to Scope of Work activities; local programs demonstrate ability to adjust program activities and services based on local data tables. *Description of how data is currently used to evaluate or plan specific activities included in* ***Appendix #_____*** ***Compliance:*** **Completed** **Yes ☐ No ☐**
7. Data will be collected during the contract year to report to the State Office the " Total Population Served" –an unduplicated count of all clients receiving services: CHA , Non-CHA, health education at a group class or health fair, or a special screening exam not done during a CHA or Non-CHA visit.	7.1 Local data may be used to: (1) Track the number of clients who have received CHA and Non-CHA assessments. **NOTE: All CHA forms will be collected for data entry into the statewide PHCA database;* ***only those Non-CHA forms with referrals documented on them will be collected for data entry into the statewide PHCA database.*** (2) Identify the number of clients who are "unduplicated" to the local program each year. (3) Measure the success of outreach and health promotion activities—as evidenced by the number of seniors attending each event.		7.1 Completion and submission of the "Total Population Served" worksheet due with the Annual Report to the State. **Total Population Served Worksheet:** ***Appendix # _____***

SUGGESTED OUTREACH ACTIVITIES

Continuous Promotion

Develop a yearly plan
Assign responsibility for specific activities

Evaluate Plan for Effectiveness

Track increased contacts after promoted event
Ask new clients how they heard about program
Survey key senior community providers
Collect demographic data to determine that target population is being reached

Promotion at Senior Events

Immunization and screening clinics (skin cancer, podiatry)
Hospitals
Senior and Community Fairs
Talks at senior centers, community organizations and support groups, physicians and pharmacists
Ethnic celebrations such as Cinco de Mayo
YWCA-walking clubs

Use Incentives and Flyers

PHCA promotional items (water bottles, jar openers, whistles)
Drawings, raffles, door prizes for other events
Focused health screening (BP checks, hearing assessments, blood sugar checks)
Teasers (ask a health question whose answer is provided when client makes appointment)
Flyers in monthly statements (banks, PG&E)
Flyers distributed in pharmacies, markets, food distribution programs, senior centers, activity centers, community colleges, senior residences, mobile home parks, and YWCA/YMCA's

Use Social Marketing Media Strategies

Local bus billboards
English and Non-English newspaper/radio/TV for senior population
Public Service Announcements (PSA)
Request and respond to interviews

Articles in local AAA newsletters/senior publications/hospital newsletters and mobile home park newsletters
Church bulletins and Parish Nurse bulletins
Yellow Pages
Media coverage for volunteer-recognition awards

Use Service Provider Network

Bring flyers to all senior network meetings. Be prepared to describe your program in one minute
Offer to talk to key staff who see seniors regularly about your program
Recruit senior center and senior housing managers to refer seniors. Offer to give them a health assessment to help them understand your program
Offer to provide training to information and referral workers who respond to senior information callers
Target recruitment of community volunteers from ethnic minority groups

PHCA CLINICS IN HEALTH DEPARTMENT FACILITIES

Based on the enabling legislation, PHCA is designed to be an outreach service to older adults. As a result most PHCA services are delivered in community settings that facilitate access by the target population. In a few circumstances, however, use of a health department site is appropriate.

The total number of CHAs provided by the contractor in all health department sites may not exceed 15% of the total number of CHAs provided in that fiscal year.

Conditions that may warrant use of a health department facility site include:

- The health department facility is the only safe and accessible space for the target population in an isolated area.
- The health department facility will be used as a temporary clinic site in a new geographic area while planned outreach activities are conducted and an appropriate site is located.
- Health department translation personnel for a particular minority group are unable to travel to established outreach sites.
- The health department facility will serve as a temporary facility when an established PHCA clinic site unexpectedly closes, and PHCA services need to continue until a new site can be located.

PHCA CLINIC SITE LIST

EACH PLANNED PHCA CLINIC SITE SHOULD BE LISTED AND THE FOLLOWING DESCRIPTIVE INFORMATION INCLUDED

1. **UNIQUE SITE NUMBER**

   A three--digit number is assigned by the local program that identifies each site where recurring PHCA services are provided. At the contractor's option, the first digit might designate a specific geographic area of the county, and the second and third digits the specific site within that area. (This allows for some regional aggregation of data by the county if desired.)

2. **SITE OR FACILITY**

   Provide the name and address of the site or facility.

3. **TYPE OF FACILITY**

   Describe the facility, e.g., senior center, nutrition site, park and recreation site, church, community center, senior residence, public health department site.

4. **FREQUENCY OF PLANNED CLINICS**

   Provide the frequency which the contractor plans to hold clinics at the site, e.g., weekly, semi-monthly, monthly, every other month, quarterly, yearly.

5. **STAFFING PATTERN**

   Identify the PHCA staff at each clinic site who will be providing clinic services, e.g., one-two PHNs, one community health aide or outreach worker. Staff must reflect the actual budgeted positions. Volunteer assistance may be identified if there is reasonable assurance this assistance will be ongoing throughout the contract year.

6. **RISK FACTORS**

   Identify the known and suspected risk factors for the seniors in the area served by the site, e.g., ethnic/cultural barriers, low income, isolation by geography or access to care, increased incidence of chronic disease or behavior risks.

7. **EVALUATING PHCA CLINIC SITES**

   Contractors are expected to periodically review their clinic sites based on data reports, ongoing PHN assessments, and outreach activities, to assure that the PHCA target population is being reached and served. During the year clinic sites may be added or changed based on these assessments. Contractors should submit a revised clinic site list (with revision date) to the State Office when changes in clinic sites are made.

HEALTH RISK REDUCTION ACTIVITIES

Examples

Examples are offered for illustration purposes. Applicants are encouraged to develop their own projects based on assessment of the needs of the local older adult population. Collaboration and community participation in development and implementation of these projects is a key factor.

1. Expand existing risk-factor identification programs

   - Risk factor screening and education on new diagnostic criteria for diabetes, type 2, made available at senior centers, malls, or other accessible area where older adults frequent. Collaboration between PHCA, American Diabetes Association, and medical care provider group.

   - Skin cancer screening event, sponsored by PHCA, local hospital, and dermatologists, including education on preventive measures with referral for treatment available to individuals with positive screening.

   - Multi-activity educational project to raise awareness of colo-rectal cancer incidence and recommended preventive screening. Collaboration with Area Agency on Aging, local hospitals, physician groups (gastro-enterologists and primary care physicians), and American Cancer Society.

2. Develop new risk factor reduction programs

   - With Assisted Living Centers, local hospital or medical provider groups, senior center site managers, develop an series of classes and/or other activities addressing fall prevention for at-risk older adults and their care givers.

   - With audiologists, ENT physicians, optometrists, DMV personnel, and ophthalmologists, develop a series of classes and demonstrations of assistive devices for older adults impaired by vision and hearing deficits, or both.

   - Develop a “healthy changes” project with local health educators, nutritionists, hospital or community health center, and local health ministries association. May include physical activity, improved nutrition, weight management, stress reduction, and spirituality.

3. Educate other community providers of services to older adults

   - Provide regional workshops to physicians and nurses on significant risk factors. Collaborate with professional groups, local hospitals, pharmacists, mental health services, and provider groups. May be one-time-only or a series of workshops on risk factors such as smoking, alcohol abuse, depression, lack of physical activity, or poor self-management of medications. Provide local data where available, local resources, or identify where gaps in services exist.

- Develop or use an existing course that teaches skills for care givers. Course is targeted to anyone providing care to a homebound, frail, disabled older adult. Content also addresses preventive health and support needs of the care givers. Collaborate with Department of Social Services, local community college, home health agencies.

- Develop a training program for volunteer seniors who express an interest to become "peer health educators." Develop structured programs on a variety of topics to be taught these volunteer leaders who will then deliver presentations to senior groups in the community. Collaborate with health educators and volunteer coordinators who work with senior volunteers in the community.

4. <u>Promote services to assist older adults in chronic disease and disability management</u>

- Develop financial and organizational support for training lay leaders to deliver the Chronic Disease Self Management Program (CDSMP). Obtain certification as "master trainers" for a pair of instructors who will in turn teach lay leaders, older adults living with a chronic disease. Older adults with a range of chronic diseases who are symptomatic are targets for this seven-week course that teaches symptom management and use of health care and community resources.

- In collaboration with local provider networks and the local chapter of the American Diabetes Association, expand the number and availability of diabetic education classes currently available, particularly to under insured older adult diabetics or those living in isolated areas.

- In collaboration with local hospitals and medical provider groups, develop a community-based model of cardiac disease management, using resources from cardiac rehabilitation programs and professionals with expertise managing chronic congestive heart failure.

Preventive Health Care for the Aging

COMPREHENSIVE HEALTH ASSESSMENT (CHA)
CHA Standards of Care

PHCA clients shall receive a comprehensive health assessment (CHA) no more frequently than every twelve months. The CHA shall include required client assessments and any optional assessments the public health nurse judges to be needed, based on the client's previous assessments, health status, and local assessment protocols.

I. CLIENT HEALTH HISTORY (required)

As part of every CHA the client (with assistance if needed) will complete a health history, using a standardized form developed for this purpose. The PHN reviews this form with the client, collects missing information, clarifies answers, identifies potential health problems, discusses health concerns with the client, and reinforces positive health behaviors.

2. NUTRITION ASSESSMENT (required)

A nutrition assessment shall be completed as part of each CHA. This assessment includes a record of the client's recent food and fluid intake, appraisal of nutritional risk factors, and the PHN's assessment if the quality and patterns of nutrition are adequate for that individual client. Standardized State forms have been developed for this activity and are required.

A full nutrition assessment is required for each new client receiving CHA services. Subsequent nutrition assessments need to collect data regarding each client's current food intake and dietary patterns.

3. PHYSICAL ASSESSMENTS (required)

Contractors must develop local protocols for all physical assessments (required and optional) provided as part of the CHA. Criteria for developing these protocols are available from the State Office and include the purpose of the test, who may receive the test, PHCA staff or volunteers who may perform the test, instructions for conducting the test/exam/measurement, criteria for normal and abnormal results, how the client is informed and counseled about the results, criteria for referral to medical services, and documentation of test results and PHN follow-up, if required, on the client's health record.

Height: Each new client's height shall be obtained by on-site measurement and repeated at least every three years for returning clients. Height shall be measured more frequently on those clients with conditions (such as osteoporosis) that may cause a more rapid change in height.

Weight: Each client shall be weighed on site as part of every CHA each year.

Blood Pressure: A blood pressure measurement will be taken on all clients at every CHA. For new clients, a blood pressure shall be taken in both arms and the results recorded. The arm with the higher reading will be used at future visits.

The numerical results of height, weight, and blood pressure will be recorded in the client's health record and on the PHCA data form.

4. PHYSICAL ASSESSMENTS (Optional)

The following physical exams, tests, or measurements are optional. They are not required as part of every CHA. They continue to be supported, however, as appropriate assessment procedures for the older adult population, based on an individual client's risk factors, and whether the client has had the exam/test/procedure in the recent past. Local protocols must describe how the PHNs will determine who receives these optional assessments. If done, the PHN must record results in the client's health record, and code the test on the PHCA data form. **Generally, if the client has been assessed within the past 12 months by a medical provider, the test should not be repeated unless the client is symptomatic, or specifically requests it.**

Pulse The rate and rhythm of the pulse will be determined by taking the radial pulse. If it is irregular, the apical pulse shall also be taken. Medications should be reviewed to determine potential relationship to any abnormalities detected.

Skin An examination of those areas of the skin most often exposed to the sun (face, neck, ears, arms, hands, scalp if exposed) will be performed to detect any abnormal changes.

Dental/ Oral An oral examination may be performed to determine the condition of the lips, tongue, gums, mucous membranes, throat, hard and soft palate, to detect dental caries, ill-fitting dentures, missing teeth, oral lesions, quality of oral hygiene, broken teeth, and periodontal disease.

Legs/ Feet An examination of the lower extremities may be performed to assess edema, color of the skin, degree of warmth of lower legs and feet, ulcers, lumps, bony growths on feet or toes, thickening or growth on soles of feet, deformities of the toes, varicosities, hygiene, and appropriate footware.

Vision The Snellen Test shall be used to measure visual acuity. Protocols must include the results at which clients will be referred for further evaluation. For clients with impaired vision, their current licensure and driving status should be assessed.

Hearing Hearing status shall be assessed through history of recent changes, previous ENT examinations, and impact on client's usual activities. Testing of client's gross hearing loss can be done through audiometry or use of self-completed questionnaire (HHIE-S). If audiometry is used, the test results at which a client will be referred to a hearing specialist must be identified in the protocols. Contractor must be able to provide evidence of regular calibration/maintenance of audiometry equipment.

Blood Glucose Testing of whole blood sample by glucometer may be appropriate for known diabetics to reinforce diabetic self care instruction. This form of screening can detect elevated whole blood glucose in high risk individuals who may need to be referred for diagnostic tests. If this screening is performed, the contractor must maintain regular records of satisfactory testing/calibrating of equipment as recommended by the manufacturer. There must be a community medical provider for the follow-up of abnormal findings.

Cholesterol Screening of all seniors should be done at least once every 5 years for total cholesterol and the HDL level (if an accurate measurement is available). Assess clients for Coronary Heart Disease (CHD) risk factors by having them complete the “risk factor questionnaire.” Clients with one or more risk factors should have lipoprotein analysis and be referred to their primary care provider for further evaluation.

Hemoglobin Testing of whole blood sample by Hemaque or other device may be appropriate in high risk individuals and those who are not using a regular source of medical care. For the latter group, there must be medical care available to follow-up abnormal findings to make screening appropriate. Contractors must demonstrate regular care and calibration of the equipment used.

Bone Density Testing and Screening Osteoporosis is diagnosed by measuring bone mass with bone mineral density tests (BMD). Clients with one or more risk factors for osteoporosis should be referred for BMD testing. The frequency of the testing varies with health status. Contractors choosing to provide this service need to consider the cost of the equipment. For others it is important to provide education and counseling on the risk factors for osteoporosis, importance of BMD testing and interpreting test results, and the role of diet, calcium, vitamin D, exercise, and medication therapy in preventing and treating osteoporosis, and fall prevention education.

FOBT Yearly Fecal Occult Blood Test (FOBT) is currently supported as one of several methods for the early detection of colo-rectal cancer. This cancer is currently the third leading cause of cancer death in seniors. Contractors wishing to provide this service need to consider the cost of supplies, laboratory services available to test returned cards, and the availability of follow-up diagnostic and treatment medical care for those with positive findings.

Immunizations The provision of on-site immunizations for pneumonia, influenza, and tetanus/diphtheria is encouraged. These services should be based on written protocols.

Urinalysis by dip-stick testing is not supported by the PHCA program. Cholesterol testing is an often-requested test by seniors. At the current time, there are few devices appropriate for PHCA clinic use and certified for use in population screening. Costs of both the devices and supplies are high, and only total cholesterol results are usually available.

Some current and former contractors offer low-cost venipuncture for a blood sample that is processed by a local laboratory with results sent to PHCA staff. The results from these tests are not always useful or applicable to the prevention focus of PHCA services. Applicants wishing to offer this service must submit, with the grant, information on what test results will be available, how this information will be used, and a justification for including it as an optional service.

5. CLIENT HEALTH PLAN (required)

The Client Health Plan is the client's document. It lists the primary health concerns identified by the PHN during the health history and nutrition review, and the physical assessment. These concerns are listed as the information is uncovered, discussed with the client, and reviewed when the assessment part of the CHA is completed. The PHN helps the client prioritize the health problems and recommends specific activities and resources available to address the concerns, (e.g., resources for low cost mammograms; opportunities to increase physical activity or join a community exercise group). Together, the client and PHN develop specific planned activities to address those problems the client chooses to address, and set a time frame to complete each activity or begin and continue a behavior change. Collaboration between client and PHN is the key to this process.

The agreed-upon plan is recorded on the client's health plan form. The client is provided a copy of this plan plus any health education materials that can assist the client in accomplishing the activities or making informed choices about health care services.

This intervention model, supported by PHCA, assumes that clients are their own health care decision makers, and can follow up on these chosen activities without other outside intervention. For a small sub-set of seniors who want to use PHCA services, clients may request that a close friend or family member attend the clinic appointment with them, and these requests are honored, especially when translation services are necessary.

Prior to the end of the CHA visit, the PHN identifies the date and reason the client will be recontacted by the PHCA program, and records this information on the client's health plan. For most clients, the next date of contact will be in one year for another CHA.

For some clients with multiple chronic diseases, complex health, functional, or psychosocial problems, or mental status changes, the PHN may consider placing the client on a health maintenance status and plan additional interventions through PHCA.

6. EDUCATION AND COUNSELING (required)

Throughout the assessment the PHN provides information, education, and counseling to reinforce current healthy practices, ensure the client understands the problems and risks identified during the assessment, and the specific actions he/she can take to reduce these risks and improve their overall health status. The PHN education activities should directly support the chosen health plan activities.

7. REFERRAL TO HEALTH PROVIDERS AND COMMUNITY SERVICES (required)

The PHN provides specific and explicit information about the local resources available to help the client accomplish his/her health plan activities. Barriers to services, such as transportation, are also addressed. Clients are coached on how to navigate through the local systems of care to be sure their problems are identified and addressed by the right providers in a timely manner.

Referrals to medical care providers for symptomatic and/or unresolved health problems, or abnormal assessment findings, are followed by the PHN over a three-month period to determine whether the client saw the provider, and if so, the outcome of the visit. This referral follow-up loop determines whether a new diagnosis or treatment was provided.

8. HEALTH MAINTENANCE SERVICES (optional)

For a small sub-set of PHCA clients who present with multiple and/or complex medical and health problems, significant depression, stress, or economic and psychosocial issues, additional interventions by the PHN may be beneficial. After each CHA, the PHN must decide if this client needs to be placed on health maintenance status. The PHN discusses this recommendation with the client whose agreement to participate in additional PHCA activities must be obtained, and code this choice on the data form. See Appendix K for Guidelines to Health Maintenance Services.

CRITERIA FOR EVALUATING THE EFFECTIVENESS OF SCREENING TESTS

In order to be effective, a screening test ideally should meet most, if not all, of the following criteria:

1. The object of the screening test should be a disease or risk factor which can have a significant effect on mortality or quality of life.

2. Acceptable, proven, and effective methods of treating the disease or modifying the risk factor must be readily accessible in the community where the screening is proposed.

3. A disease which is subject to screening must have an asymptomatic phase during which detection and treatment significantly reduce morbidity and/or mortality compared to treatment initiated after the appearance of symptoms.

4. The test to detect the risk factor or disease must be easy to administer, inexpensive, acceptable to the majority of those to be screened, and reasonably sensitive and specific.

5. The disease or risk factor to be detected must be sufficiently prevalent to justify the cost of screening.

6. The overall reduction in morbidity and mortality resulting from modification of risk factors or treatment of disease detected by screening must substantially exceed any morbidity or mortality which may result directly or indirectly from screening in any of the following ways:

    a. complications of the diagnostic evaluation of the client with a true or false positive test result;

    b. anxiety produced in those who receive false positive results;

    c. complications of treatment.

7. For community screening programs, the disease or risk factor which is the subject of screening should be one that is not already effectively detected through the population's routine encounters with the health care system.

COLLABORATING INDIVIDUALS AND ORGANIZATIONS

Definitions and Examples

1. DEFINITION OF COLLABORATING INDIVIDUALS AND ORGANIZATIONS

These are preventive health resources who provide health services to older adults or who influence the scope and accessibility of health promotion and disease prevention services for older adults. Examples include the following:

A. INDIVIDUAL PROVIDERS

Nurses, physicians, social workers, nutritionists, and health educators.

B. ORGANIZED PROVIDERS

Hospitals, pharmacies, clinics, home health agencies, health maintenance organizations, managed care organizations, local dental and physician groups.

C. HEALTH-RELATED COMMUNITY ORGANIZATIONS

American Cancer Society, American Diabetes Associations, American Lung Association, task groups addressing smoking cessation, mental health services and alcohol abuse.

D. TARGET POPULATION ORGANIZATIONS

Demonstrate interest and ability to reach and serve PHCA target population: Local Area Agency on Aging, senior commissions and networks, civic organizations such as Lions Club, parks and recreation service providers, bilingual community organizations service ethnic/cultural groups, religious organizations.

Preventive Health Care for the Aging

BUDGET GUIDE

Nov. 1, 2004 - June 30, 2006

Personnel

- List each budgeted PHCA **position by title** (do not use individual names of person with that title).

- Provide the **% of time** position is budgeted to PHCA. For consultant time (e.g. a nutritionist or translator) indicate the number of hours budgeted to PHCA and the hourly rate in the monthly salary range column.

- Provide the minimum and maximum monthly (or bi-weekly**) salary range** for that position. The top-of-range figure must be sufficient to cover any salary increases which will appear on State invoices during the proposed fiscal year.

- For each position indicate the amount (or "-0-") of that position's cost that is **budgeted as County and State** share, followed by the **total amount** budgeted to that position.

- Provide a line for **subtotal of salary costs** followed by **estimated % of benefits and costs** for the fiscal year. If different positions have different percentages, provide the range of applied percentages. The State share of benefit costs cannot exceed 30% of all salary costs budgeted to the State share. Excess benefits costs for State-funded positions may be used as county match.

- Provide a **total of all personnel costs.**

- Indirect costs not directly associated with the program's deliverables may be billed to the State award but shall not exceed 10% maximum of the total direct costs. Examples of indirect expenses include that following: payroll services, utilities, janitorial services, etc.

Operating Expenses

- Budget in sufficient line items so unexpected operating costs or program needs can be met during the fiscal year. Cumulative line item shifts of up to $25,000 or 10% of the annual agreement total may be made, whichever is greater, up to a cumulative annual maximum of $50,000 provide the annual agreement total does not increase or decrease.

- Each line item must directly support the operation of the PHCA program. Explanations of individual line items must reflect this application.

- **Supplies** are budgeted to support clinic operations and may include (small equipment such as BP cuffs, glucometers, lancets, gauze, latex gloves, table covers, otoscopes, Snellen Vision charts, gauze, scales, tape measures, flashlights.

- **General Expense** may include office space if the cost is directly allocated to the program (provide cost per square foot x # of sq. ft. x # of months) or use of space at a PHCA clinic if the host organization levies a charge, office supplies, printing costs, records storage, postage, equipment repair, storage and transport containers for clinic supplies, and PHCA outreach materials not supplied by the State PHCA Office.

- **Communications** may include phone, FAX and computer lines when these costs are allocated directly to the PHCA program. Describe the method of calculating costs.

- **Travel:** Indicate the rate per mile and estimated total number of miles budgeted. Reimbursement for any mileage charged to the State is limited to 34 cents per mile.

- **Meetings**: Budget a one (1) day statewide meeting (travel, lodging, and registration for at least two PHCA staff) as State share. These funds cannot be transferred for another use.

- **Professional Education:** Budget for Geriatric Assessment Workshop (one-day) or other local training that directly relates to older adults and PHCA services. Category may include educational journals and books.

- **Health Education Materials:** Budget for booklets, videos, pamphlets, and other health education materials that are given out to clients seen in PHCA clinics.

Travel Reimbursement Information
Effective *July 1, 2004*

1. The following rate policy is to be applied for reimbursing the travel expenses of persons under contract. *The terms "contract"' and/or "subcontract" have the same meaning as "grantee" and/or "subgrantee" where applicable.*

   a. Reimbursement *for travel and/or per diem* shall be at the rates established for nonrepresented/excluded state employees*. Exceptions to DPA lodging rates may be approved by DHS upon the receipt of a statement on/with an invoice indicating that such rates are not available.*

   b. Short Term Travel is defined as a 24-hour period, and less than 31 consecutive days, and is at least 50 miles from the main office, headquarters or primary residence. Starting time is whenever a contract *or subcontract* employee leaves his or her home or headquarters. "Headquarters" is defined as the place where the contracted personnel spends the largest portion of their working time and returns to upon the completion of assignments. *Headquarters may be individually established for each traveler and approved verbally by the program funding the agreement. Verbal approval shall be followed up in writing or email.*

   c. Contractors on travel status for more than one 24-hour period and less than 31 consecutive days may claim a fractional part of a period of more than 24 hours. Consult the chart appearing on page 2 of this exhibit to determine the reimbursement allowance. All lodging must be receipted. If contractor does not present receipts, lodging will not be reimbursed.

      (1) Lodging (with receipts):

Travel Location / Area	***Reimbursement Rate***
Statewide (excluding the counties identified below)	$ 84.00 plus tax
Counties of Los Angeles and San Diego	$110.00 plus tax
Counties of Alameda, San Francisco, San Mateo, and Santa Clara.	$140.00 plus tax

Reimbursement for actual lodging expenses exceeding the above amounts may be allowed with the advance approval of the Deputy Director of the Department of Health Service or his or her designee. Receipts are required. *Receipts from Internet lodging reservation services such as Priceline.com, which require prepayment to that service, ARE NOT ACCEPTABLE LODGING RECEIPTS and are not reimbursable without a valid lodging receipt from a lodging establishment.*

(2) Meal/Supplemental Expenses (with or without receipts): With receipts, the contractor will be reimbursed actual amounts spent up to the maximum for each full 24-hour period of travel.

Meal / Expense	**Reimbursement Rate**
Breakfast	$ 6.00
Lunch	$ 10.00
Dinner	$ 18.00
Incidental expenses	$ 6.00

d. Out-of-state travel may only be reimbursed if such travel *is necessitated by the scope or statement of work* and has been approved in advance by the program with which the contract is held. For out-of-state travel, contractors may be reimbursed actual lodging expenses, supported by a receipt, and may be reimbursed for meals and supplemental expenses for each 24-hour period computed at the rates listed in c. (2) above. For all out-of-state travel, contractors/subcontractors must have prior *DHS written or verbal* approval. *Verbal approval shall be confirmed in writing (email or memo).*

e. In computing allowances for continuous periods of travel of less than 24 hours, consult the chart appearing on page 2 of this *exhibit*.

f. No meal or lodging expenses will be reimbursed for any period of travel that occurs within normal working hours, unless expenses are incurred at least 50 miles from headquarters.

2. If any of the reimbursement rates stated herein are changed by the Department of Personnel Administration, no formal contract amendment will be required to incorporate the new rates. However, DHS shall inform the contractor, in writing, of the revised travel reimbursement rates.

3. For transportation expenses, the contractor must retain receipts for parking; taxi, airline, bus, or rail tickets; car rental; or any other travel receipts pertaining to each trip for attachment to an invoice as substantiation for reimbursement. Reimbursement may be requested for commercial carrier fares; private car mileage; parking fees; bridge tolls; taxi, bus, or streetcar fares; and auto rental fees when substantiated by a receipt.

4. **Note on use of autos:** If a contractor uses his or her car for transportation, the rate of pay will be **34 cents** maximum per mile. If the contractor is a person with a disability who must operate a motor vehicle on official state business and who can operate only specially equipped or modified vehicles they may claim a rate of **37 cents** per mile. If a contractor uses his or her car "in lieu of" airfare, the air coach fare will be the maximum paid by the State. The contractor must provide a cost comparison upon request by the state. Gasoline and routine automobile repair expenses are not reimbursable.

5. The contractor is required to furnish details surrounding each period of travel. Travel *expense reimbursement* detail may include, but not be limited to: purpose of travel, departure and return times, destination points, miles driven, mode of transportation, etc. *Reimbursement for travel expenses may be withheld pending receipt of adequate travel documentation.*

6. Contractors are to consult with the program with which the contract is held to obtain specific invoicing procedures.

Travel Reimbursement Guide

Length of travel period	This condition exists…	Allowable Meal(s)
Less than 24 hours	Travel begins at 6:00 a.m. or earlier and continues until 9:00 a.m. or later.	Breakfast
Less than 24 hours	• Travel period ends at least one hour after the regularly scheduled workday ends, or • Travel period begins prior to or at 4:00 p.m. and continues beyond 7:00 p.m.	Dinner
24 hours	Travel period is a full 24-hour period determined by the time that the travel period begins and ends.	Breakfast, lunch, and dinner
Last fractional part of more than 24 hours	Travel period is more than 24 hours and traveler returns at or after 8:00 a.m.	Breakfast
	Travel period is more than 24 hours and traveler returns at or after 2:00 p.m.	Lunch
	Travel period is more than 24 hours and traveler returns at or after 7:00 p.m.	Dinner

7. At DHS' discretion, changes or revisions made by DHS to this exhibit, excluding travel policy established by DPA may be applied retroactively to any agreement to which a Travel Reimbursement Information exhibit is attached, incorporated by reference, or applied by DHS program policy.

Contractor's Release

Instructions to Contractor:

With final invoice(s) submit one (1) original and two (2) copies. The original must bear the original signature of a person authorized to bind the Contractor. The additional copies may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** _____ entered into between the State of California Department of Health Services (DHS) and the Contractor (identified below), the Contractor does acknowledge that final payment has been requested via **invoice number(s)** _____, in the **amount(s) of $** _____ and **dated** _____ .
If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt of the amount specified in the invoice number(s) referenced above, the Contractor does hereby release and discharge the State, its officers, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing this form, Contractor acknowledges that expenses authorized for reimbursement does not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment, will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a percentage (0% to 100%) of the materials, goods, supplies or products offered or used in the performance of the above referenced contract meets or exceeds the minimum percentage of recycled material, as defined in Public Contract Code Sections 12161 and 12200.

Reminder to Return State Equipment/Property (If Applicable)

(Applies only if equipment was provided by DHS or purchased with or reimbursed by contract funds)

Unless DHS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another DHS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to DHS, at DHS's expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

ONLY SIGN AND DATE THIS DOCUMENT WHEN ATTACHING TO THE FINAL INVOICE

Contractor's Legal Name (as on contract): _____

Signature of Contractor or Official Designee: _____ Date: _____

Printed Name/Title of Person Signing: _____

DHS Distribution: Accounting (Original) Program CMU contract file

GUIDELINES FOR HEALTH MAINTENANCE SERVICES

"Health Maintenance Service" is defined as the planned delivery of PHCA services to an individual older adult who has already received an initial or yearly comprehensive health assessment (CHA) and, in the view of both the client and the nurse, would benefit from additional PHCA assistance to manage chronic health problems and to utilize community resources.

1. Eligible Clients Any at-risk PHCA client who has received a CHA and falls in one or more of the following categories:

   - **Complex medical history:** genetic risk factors and/or one or more chronic diseases and/or sensory impairment which have contributed to functional and life-style changes. Examples may include osteoarthritis, diabetes, cardio-vascular disease, stroke, loss of vision, hearing.

   - **Mental Health Factors:** depression, anxiety, social isolation, low self-esteem, history of alcohol and drug misuse, mental status/memory impairment, personal and family-related stress or loss.

   - **Residential, social, economic factors:** uninsured or under insured, inadequate income to purchase food and medicines, lack of access to transportation, low educational level, cultural and/or language barriers, community lacks medical services, recently relocated, unaware and unconnected to community services, lacks needed caregiver assistance.

   - **Poor medical treatment compliance, safety risks:** misuse of prescribed and OTC medicines, history of falls and injuries, poor understanding of chronic illness and self-management, more frequent emergency room use.

   - **Unhealthy life style behaviors:** Lacks information, understanding, and/or motivation to modify risks such as smoking, alcohol misuse, obesity, sedentary life style, poor nutritional choices, inappropriate use of medical care services.

2. Specific additional PHCA Services that may be provided:

   - **Return Clinic Visits**: The client is scheduled for follow-up clinic visits to expand education and counseling on specific health problems, reassess an ongoing health problem, recommend specific "homework" activities or arrange for additional resources.

   - **Telephone Follow-up with client:** Planned and periodic phone contact with the client to reinforce health plan activities, provide additional information and counseling, reinforce positive behaviors, clarify the clients role in use of community resources and services.

   - **Telephone Follow-up with community providers:** With the clients permission, PHN contacts the physician or other community service providers to obtain information and/or arrange for additional services.

- **Home Visits:** A home visit may be made only when there is no other way of obtaining the critical information needed or assessing the problem, and there is significant concern for the client's health and safety.

  A home visit may not be made to provide a CHA. It can be made only to clients who have already received a CHA, and are either actively being carried as a health maintenance client, or are known to PHCA and have had a sudden change in health status that places them at risk.

  Home visits are an optional service that individual contractors may or may not decide to provide.

  Home visits are limited to no more than 3% of all encounters in a given fiscal year for any individual contractor, or approximately 25 home visits per year for a contractor completing 500 CHAs. (Calculation is 500 x 1.75 [current average # of encounters/CHA client] x .03 = 26).

3. The use of health maintenance services must be evaluated by the PHN on an ongoing basis. After each documented encounter, the PHN must consider whether the objectives set by the client and nurse together are being met, indicate, on the data form, whether or not that client continues on a health maintenance program.